

Leading with compassion in health care organisations: the development of a compassion recognition scheme-evaluation and analysis

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Leading with compassion in health care organisations: the development of a compassion recognition scheme-evaluation and analysis

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5 **Introduction**

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7 Compassion is central to the purpose of medicine, yet health professionals around the globe

8 face numerous challenges that impede their ability to form meaningful connections and

9 relationships with patients (Lown, 2014). One of the values identified in the **National Health**

10 **Service (NHS)** Constitution is that: *...we ensure that compassion is central to the care we provide*

11 *and respond with humanity and kindness to each person’s pain, distress, anxiety or need.* (DH, 2015,

12 p.5). Although compassion can be interpreted in different ways (Blomberg *et al.*, 2016, Strauss *et al.*,

13 2016), it is often used synonymously for ‘good’ patient care. For example West and Dawson

14 (2011, p.7) argue *that cultures of engagement, positivity, caring, compassion and respect for*

15 *all - staff, patients and the public - provide the ideal environment within which to care for*

16 *patients.* With the aim of creating such environments of care the *Leading with Compassion*

17 programme was launched in Shropshire and Staffordshire, England in 2015. Its purpose was

18 to embed, recognise and research compassionate leadership. This approach was grounded on

19 the precept that all staff involved in the delivery of care must be treated with kindness and

20 experience compassionate leadership (National Improvement and Development Board 2016;

21 West *et al.*, 2014a; Shipton *et al.*, 2008). The intention was to engage all staff in recognising

22 and celebrating compassion whether it was experienced by a patient, carer, or colleague. As

23 part of this work a *Leading with Compassion Recognition scheme* was introduced in health

24 and social care organisations in the West Midlands of England in early 2016. In the course of

25 the development and introduction of this scheme a new perspective on the nature of

26 compassion and how best to acknowledge it in organisations emerged. The purpose of this

27 paper is to discuss this process and examine a new typology of compassion that has been

28 developed. It will also explore the potential benefits of this approach in a wider range of

29 health and social care organisations. Its principal contribution in terms of knowledge in this

30 area is in the analysis of compassion as characterised in over 1500 individual accounts of

31 compassionate acts.

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Background and related literature

Compassion is seen as being integral to 'good' healthcare (Royal College of Psychiatrists, 2015; DH, 2015, 2014; Nursing and Midwifery Council, 2015) and it is one of the 6Cs in the National Nursing and Midwifery strategy (Compassion in Practice NHS England, 2012). **They are care, compassion, competence, communication, courage and commitment and their purpose is to define a vision to reinforce the values and beliefs that underpin care in an easily understood and consistent way to explain the values of care (Compassion in Practice NHS England, 2012).** First identified in the Compassion in Practice strategy it was later emphasised that the 6Cs:

*...belong to **all** health and care staff from nurses, midwives, doctors, porters, care staff, physiotherapists and managers both clinical and non-clinical, to executive Boards and commissioning Boards (DH, 2013, p. 24). (our emphasis)*

Compassion has been defined as *a sensitivity to suffering/distress in self and others with a commitment to try to alleviate and prevent it* (Cole-King and Gilbert, 2011 p. 30) so to behave compassionately involves recognising a need in others, motivation to respond to it, and the knowledge and skills necessary to competently meet it. This can be challenging in highly pressurised health and social care organisations (Lown, 2014; Mannion, 2014). However if compassionate leadership is enacted, compassionate organizations can be developed which enable people to be compassionate towards each other (Gilbert, 2009).

The importance of creating a compassionate environment for care has been the focus of a number of large studies/programmes which have sought to examine what was required to achieve this and its impact. Three are reviewed here briefly as examples of the work that is underway in this area, and to provide context for the innovation reported here. The first to be considered is the Leadership in Compassionate Care Programme (LCCP) which was developed by Napier University working in partnership with NHS Lothian, Scotland (Napier University & HNS Lothian, 2012). It had four main strands:

1. Embedding the principles of Compassionate Care in the undergraduate nursing curriculum.
2. Supporting newly qualified nurses during their first year in practice to facilitate the transition from student to competent and compassionate staff nurse.
3. Establishing NHS Lothian centres of excellence in Compassionate Care – called Beacon Wards.
4. Supporting development of leadership skills in Compassionate Care.

The design, implementation and evaluation of this programme has been reported widely (see for example: Dewar and Kennedy, 2016; Dewar and Cook, 2014; Dewar and Nolan 2013; Smith *et al.*, 2010; Smith *et al.*, 2017) and the key areas of impact identified include improvement in relational practices, that is communication with patients and between staff; practice development, involving supporting ward teams to acquire new skills and ways of working; and leadership at all levels to embed compassionate care (Dewar and Cook, 2014; Dewar and Nolan, 2013; Smith *et al.*, 2010; Smith *et al.*, 2017). This involved focussing on the needs of staff and supporting them to develop and work in a shared culture of compassion, based on a strategic vision for compassionate care which emphasised and valued the role of relationships, practice development and leadership at all levels (MacArthur *et al.*, 2017). Although its primary focus was on nursing, there was consideration of the wider staff group and the importance of leadership, which were central to the *Leading with Compassion* programme reported here (see below).

A similar approach, in terms of its partnership model and focus, is the Cultivating Compassion project (<https://cultivatingcompassionatecare.wordpress.com/>) involving two universities, four NHS organisations and service users. Its aim was to develop a sustainable programme of compassion awareness training for a wide range of health care organisations (Curtis *et al.*, 2017). Using a ‘train the trainers model’, and an on-line toolkit (<https://cultivatingcompassionatecare.wordpress.com/the-tool-kit/>), nested in an Appreciative Inquiry approach, the project sought to develop an evidence based programme of compassion awareness training to promote compassionate care. Although some participants were sceptical and organisational barriers hampered the roll out of the programme, one of the main conclusions, relevant to the present discussion, is the importance of senior level support and organisational leadership in cultivating compassion in health care organisations (Curtis *et al.*, 2017).

The third project was the Creating Learning Environments for Compassionate Care (CLECC) programme. It was designed to promote compassionate care for older hospital patients and is focussed primarily on ward teams in hospitals (Bridges and Fuller, 2013). It involves:

1. Creating an expansive workplace learning environment that supports work-based opportunities for the development of relational practices across the work team;

2. Developing and embedding sustainable manager and team relational practices such as dialogue, reflective learning and mutual support;
 3. Optimising and sustaining leader and team capacity to develop and support the relational capacity of individual team members;
 4. Embedding compassionate approaches in staff/service-user interaction and practice, and continuing to improve compassionate care following the end of programmed activities.
- (Bridges and Fuller, 2013).

It involves a four month programme, and whilst there have been some promising beneficial effects it is acknowledged that the effectiveness of the programme has yet to be demonstrated, and there is a need for robust evaluations (Bridges and Fuller, 2014). A comprehensive study of this intervention is in progress with the report scheduled for 2018 (National Institute for Health Research, 2017). One of the unifying themes of these three programmes is the importance of leadership in the provision of compassionate care. This is also identified in *Developing people - improving care* (NHS Improvement, 2016), which states: *Compassionate leadership means paying close attention to all staff; really understanding the situations they face; responding empathetically; and taking thoughtful and appropriate action to help* (p. 2)

The Leading with Compassion Recognition Scheme

The approach taken by the healthcare community in Shropshire and Staffordshire, supported by Health Education England West Midlands, shared some similarities with these programmes, in that it involved the development of a shared vision to recognise and embed compassionate leadership in the region. Initiated in 2015 the Shropshire & Staffordshire Community of Practice (S&SCOP) came together to share good practice and innovation concerning *Leading with Compassion*. This involved consideration of the nature of leadership as envisaged in the scheme. There are over 400 definitions of leadership (Crainer, 1995), there is an extensive literature on the nature of leadership (see for example Bryman *et al.*, 2011 for a helpful discussion), and there is an emerging literature focussed on the NHS in England which challenges 'traditional' notions of leadership as relating to hierarchy and vested in a small number of individuals (West *et al.*, 2014b, King's Fund, 2011). Set against this complex and developing context of leadership, the work was predicated on a shared understanding of leadership being a part of the role of everyone working in health care. The fundamental principle underpinning the scheme was that 'compassionate leadership is everyone's business' (NHS England 2014, p12). This is also evident in the *Health Care Leadership*

Model (NHS Leadership Academy 2013) which is aimed at all staff whether they have ‘formal’ leadership responsibility or not and whatever setting they work in. . The perspective of the project team could be regarded as a form of ‘Distributed Leadership’ whereby leadership responsibility is less associated with formal organisational roles, and more about the action and influence of people at all levels as integral to the overall direction and functioning of the organisation (Bolden, 2011, Currie *et al.*, 2011). Although there are critiques of this perspective (Martin *et al.*, 2015), it was the basis for the development of the leading with compassion recognition scheme in that demonstrating and recognising compassion were regarded as elements of leadership activity.

This in turn led to the development of a recognition scheme which has been introduced in ten health and social care organisations so far. The aim was to develop a simple scheme, whereby staff, patients and carers could nominate someone who they felt had demonstrated leading with compassion. The scheme is described below and some emerging evidence of its impact is considered. In particular the accounts of compassion generated as part of the scheme are analysed. Finally the implications of this work for the organisation of compassionate care are considered.

The scheme was designed to acknowledge and reward compassionate acts witnessed ‘in the moment’. It was designed to be straightforward, ‘user friendly’ and place no restrictions on who could make nominations (staff or patients/service users) or be nominated (<http://www.nhscompassion.org/compassion/>). Nominations are made by completing a card and posting it in a box designated for the scheme placed in central locations in the participating organisations or using the scheme website (<http://www.nhscompassion.org/compassion/organisations/>). Nominees then receive a card explaining who nominated them, the reasons for the nomination, and a badge which indicates they have been recognised for acting compassionately. All nominations were collated and analysed. In excess of 1500 nominations had been made at the point an evaluation of the scheme was undertaken to capture the lessons learned from this innovation which is reported below. To date 3651 nominations have been made with 59% of the total made by staff and 49% by service users.

The Evaluation Method

The evaluation was a retrospective review to examine: What helped and/or hindered the roll out of the scheme? This involved a small number of one-to-one telephone interviews and a focus group. A purposive sample (Kuzel, 1992; Teddlie and Yu, 2007) of eight staff, drawn from the ten participating organisations with knowledge of the design and implementation of the scheme, and who had all nominated someone for recognition were interviewed. Semi-structured interviews are an effective method for accessing the views and experiences people working in health care (Fontana and Frey, 1994; King, 1994; Seale, 1998).

A small focus group was also conducted to collect the views and experiences of other staff who had nominated colleagues (Kitzinger, 1994; Wellings *et al.*, Branigan and Mitchell, 2000). Despite the limited attendance, (three participants) the focus group yielded some additional data. The project received ethical approval from the Humanities and Social Sciences Research Ethical Review Committee of the University of Birmingham (ERN_13-1085P).

Findings

The thematic analysis of the participants' accounts was conducted in line with the principles of a cyclical approach involving identification of patterns, consideration of variations and limitations and building explanations (Porter, 1996). In order to conduct this analysis the recorded interviews were listened to several times and detailed notes made of key phrases, along with verbatim transcripts of some statements. Full transcription was not possible because of budgetary constraints. However repeated listening, detailed contemporaneous notes and focussed, partial transcription provided a comprehensive record of the data for analysis. Codes were assigned to notable extracts that signified key issues in the data (Miles and Huberman, 1994). These were then reviewed and grouped into categories reflecting the main areas addressed by the participants (Strauss and Corbin, 1998; Charmaz, 2006). These categories informed the development of four themes which characterise the introduction of the *Leading with Compassion* recognition scheme. Selected extracts from the data are included to indicate the nature of the themes. These themes were: Purpose; Communication; Progress; and Tensions. The focus group findings are incorporated in these themes.

Purpose

The purpose of the scheme was to develop compassionate leadership and this was discussed in the interviews. One interviewee described it as a tool to raise awareness and move compassion 'higher up the agenda', making people think about 'how you feel and how you make others feel' and that this was at the heart of compassion. Others said it was a way of recognising 'we are all human', and fostering mutual support for each other. For example:

"It's the little things people remember- they don't remember the policies and strategies, but how they were treated." (Senior Nurse)

The extent to which the *Leading with Compassion* recognition scheme was associated with 'leaders' and approaches to leadership influenced the way it was introduced. This was related to the purpose of the scheme as envisaged in each organisation:

"Some organisations have incorporated it with their organisational values, I'm not sure how they've evaluated it. We've gone bigger on the leading with compassion rather than incorporating it into values." (Head of Organisational Development)

Whereas elsewhere it was approached in a different way:

"It's a motivational scheme in our organisation so it's about having that recognition process without it being too formal to say thank you, which we're not always great at in terms of making sure people are recognised for something that might seem quite trivial, it can have a big impact on others, so we've done it for those reasons really." (Organisational Development and Engagement Manager)

One respondent felt the scheme added value because it was inclusive:

"There is no need for big glitzy events- the informality and the human touch element of the recognition is important." (Focus Group, Clinical Commissioning Group Lead)

The respondents valued the openness of the scheme, as compassion was often seen as being mainly in the domain of clinical staff, and this demonstrated that it exists across the wider workforce. However whilst there was overall agreement that the purpose of the scheme was to recognise and reward acts of compassion, some reservations were expressed. The participants agreed that recognition needed to be embedded in the everyday work of colleagues as part of 'how we do things around here', in this way it would be a useful reinforcement of required behaviours. The scheme was seen for the most part as a positive development in contributing to this.

How the scheme fitted with the longer term aims and aspirations of the different organisations varied depending on location. For some it was seen as time limited:

“What we aim to do for this year, it’s been care and compassion, next year I don’t know what’s going to happen with this scheme but if it finishes we’ll probably pick another one of our values and do it around that, get recognised for that and keep it rolling”. (Organisational Development and Engagement Manager)

However for other respondents it was seen as a means of embedding compassionate behaviour as part of a longer term programme of development:

“What I would like to see from the scheme specifically is a combined data set that gives us a view of what people do think compassion is- gives us an opportunity to build into our existing programmes ‘this is what staff think compassion is, this is what patients think it is, it is an evidence base, its scaleable to 10 organisations’. It makes sense that we’ve got a lot of data, between 1000-2000 entries now to give us a view of what compassion is.” (Deputy Head of People, Organisation and Development)

The respondents generally felt the scheme had achieved its purpose in terms of raising the profile of compassion, and also created a ‘feel good factor’ on the part of the nominees and nominators.

Communication

The participants became aware of the scheme in different ways. For example one Chief Executive had heard about it from a colleague in another organisation and wanted to start it in his own hospital. In another the scheme was publicised at an annual all staff event. The scheme was also implemented in a variety of ways with approaches ranging from formal launches to informal/personal ‘spreading of the word’ with one respondent reporting she had been invited to visit another hospital to talk about the scheme, as it was felt that word of mouth would be a more powerful and effective way of increasing its uptake.

However continuing communication was reported to be limited, for example one participant thought the scheme had now ‘closed’ and whilst some organisations had put posters in prominent places in public areas to encourage nominations from patients/service users, some participants were not aware that patients/service users could make nominations. Also some respondents reported that most hospitals already had a number of ways of acknowledging staff contributions in place, such as annual staff awards, and quality awards, and it was not clear how the compassion recognition scheme fitted with these. They identified a need to

emphasise that the *Leading with Compassion* recognition scheme was not an organisational award.

Some organisations started with executive ‘ownership’ and a top-down communication and support strategy. In another it was reported that:

“The intention was always to have that soft approach, social movement as we had been advised that had worked really well in other organisations, if we had a number of initiatives that are all supporting a compassionate culture and leadership approach that would be the social movement element of that strategy really.” (Head of Organisational Development)

One hospital conducted a ‘flash communication’ which involved the distribution of 1000 leaflets explaining the *Leading with Compassion* recognition scheme by the Organisational Development team dressed as Queens of Hearts. In other examples some of those responsible for the roll out of the scheme added the award website link to their email signatures but acknowledged that not all operational staff accessed emails so this limited its spread. The scheme was highlighted in monthly meetings; team briefs; newsletters; health and well-being events, and in Chief Executives’ blogs. Yet despite this considerable effort devoted to publicising the scheme, the levels of awareness of its existence varied:

“I only knew how to nominate because I am an ex -employee and knew patients can nominate staff from this and it was only when I logged on to nominate my colleague I saw I could also nominate a member of staff” (Service User)

Similarly

“I work within two roles in the trust and only know about the scheme from the one department as we were given the link with a video telling us about it at a group operations meeting, however in my other role I have received nothing to alert me to the scheme so maybe the word needs spreading a little bit more...” (Focus Group, Administrative Support Manager)

For those with less formal or more ‘bottom up’ implementation plans, it was thought that future introductions of the scheme may require more visible executive endorsement. For example:

“One of the biggest barriers seems to be executive buy in and we haven’t as a centralised team wanted to impose our stance, we wanted to enable the nurse director or OD director to gain traction themselves, all of the branding is bespoke to each organisation, we did not want to force something on an organisation that doesn’t work, but there is definitely a connection between really strong executive buy in for the programme from the off, versus trying to do a soft launch in the absence of their real understanding of what the programme’s about.” (Director of People and Strategy)

The interviewees believed the scheme needed more promotion, because as one respondent commented: 'It doesn't feel like it's got a life yet'. Overall the importance of effective communication of the details and operation of the scheme was acknowledged, and it was felt there was a link between the approach taken and the take up rate of the scheme.

Progress

The number of nominations and participating organisations increased steadily during the conduct of the evaluation, suggesting progress was being made with implementation. Indeed those respondents responsible for the scheme were generally pleased with the rate of adoption. For example:

"...the take up has been very high, higher than we anticipated and the feedback we get from those workshops is hugely positive." (Head of Organisational Development)

Although as noted earlier, this related directly to way it was launched/publicised in the organisations:

"given it's been quite a soft comms launch, we've done a bit, we've done enough probably, alongside a lot of other things, it's been steady, I wouldn't say it's been massive at all, but it hasn't been our priority, it wasn't one of our directorate or organisational priorities but it has done what it was designed to do" (Organisational Development and Engagement Manager)

Yet given the plethora of organisational initiatives, targets and other pressing concerns faced by the organisations involved, the 3651 nominations to date indicate that the scheme has taken hold, albeit at different rates. This was reflected in the fact that in one organisation 200 nominations were made in 6 months, whereas in another only four were received in the same period. Even allowing for differences in size and location this is quite a contrast.

"The recognition scheme has been taken up variably in the different organisations. Some have got it instantaneously and are motoring through their organisation because they had a culture that enabled it to land and take fire, whereas in other organisations there just hasn't been the culture, 'why would we?' 'we haven't got permission to recognise each other', so it has taken a longer lead in time" (Director of People and Strategy)

In terms of the operation of the scheme it was reported to be straightforward. This was important because it was consistent with one of its founding principles:

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2
3 *“What are we trying to spread here? All access, all areas anyone can nominate*
4 *anyone else and there should be no barriers to that whatsoever, because it’s*
5 *subjective, and that person’s reflection is their own so we shouldn’t try to interpret it,*
6 *it is their own”* (Director of People and Strategy)
7

8 However, some respondents felt that the option of being anonymous would be helpful,
9 particularly for service users, who might feel awkward meeting a staff member they had
10 nominated. Indeed some of the staff making the nominations did not know they would be
11 ‘named’ as the person making the recommendation when the recognition was conferred.
12 Also one interviewee noted that the person she nominated, though pleased, was a little
13 embarrassed and put her badge in her drawer rather than wear it, as she felt it was ‘showing-
14 off’.
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21 In general the badges were seen as an important acknowledgment of the contribution made by
22 the staff member, and also an opportunity to publicise the scheme more widely, as many staff
23 wore them on their lanyards. For example:
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26

27 *“I have been in a couple of meetings where people have mentioned that they have the badge*
28 *and showed it off proudly and that advertises the scheme really.”* Focus Group, Clinical
29 Commissioning Group Lead)
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32 Aside from the staff time necessary for the development and launch of the scheme, in terms
33 of its operation it was relatively inexpensive-
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36 *“... each act of recognition costs about £2.00¹ (for the production of the badge and the card)*
37 *so in terms of them being able to set that up it is fairly small beer in terms of the benefit it*
38 *brings to the individual, morale and engagement”* (Director of People and Strategy)
39
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41 The nomination process involved answering two questions – what did that person do and how did
42 it make you feel? It was open for all staff and service users to access and could be completed in
43 a short space of time. This was seen to be important in terms of generating engagement with
44 the scheme. Overall the participants were positive about the progress of the scheme although
45 they agreed it needed to be managed differently, dependent on the setting (for example a
46 more ‘personal’ approach to publicising the scheme could be taken in smaller organisations).
47 However as with any initiative of this nature there were some inherent tensions which are
48 discussed below.
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Tensions

The interviewees had some interesting insights on a number of issues associated with the *Leading with Compassion* recognition scheme. These centred primarily on the extent to which the scheme could work counter to its original aims as a result of the way it was introduced, perceived and supported. For example one respondent felt there was a risk to consider if the scheme continued and awareness of it increased:

“The danger is as it grows is that if you haven’t got one (a badge) you are [seen as] not very compassionate, so if the scheme grew beyond itself it could be counterproductive where some people are going ‘why haven’t I got a badge’ ‘why has no one seen this in me’ so that can be a fine balance as well” (Deputy Head of People, Organisation and Development)

The association of the scheme with the term ‘leadership’ was felt to be a bit ‘off putting’ and uncertainty as to whether performance of a compassionate act could always be classified as ‘leadership’ was identified as an issue. Indeed the participants said they ‘sometimes had to tweak the nomination’ to reflect this. In some organisations the leadership element was prominent, whereas in others the emphasis was more on compassion and less on its association with leadership. One interviewee suggested that calling it ‘a moment of compassion’ might be more engaging and help make more staff/patients aware they can make nominations. However, there was agreement about the importance of having a wider view of compassion and that it is not just about patient care – ‘it is about staff looking after each other’, and that the scheme reflected this.

Another tension was concern about what the scheme should be seen to be recognising:

“...we shouldn’t get too enthusiastic about recognising people going above and beyond, because in this organisation we have many, many, many people who go way above and beyond and we do not want to create a culture where that is expected, we want to create a culture where people can and are able, and willing to go above and beyond where they choose to do that, but not having a recognition scheme that only recognises when people are working extra hours.” (Head of Organisational Development)

Another concern was that compassionate care should be the norm in the NHS and therefore rewarding people for delivering ‘an everyday expectation’ invoked some disquiet and some felt there could be criticism for funding such a scheme in a period of austerity. For example it was felt there was a risk in ‘separating it out’ (the recognition of compassion)-with one focus group participant stating *“Will it really change the culture? No. Will it have any massive impact in the long term? No.”* However it was felt that these were issues for the

future as participation in the scheme was far from being at ‘saturation point’. Despite the tensions of introducing this scheme alongside a number of other initiatives, the respondents felt it was important to model compassion at all levels, and this scheme enhanced rather than detracted from this cultural aspiration.

Summary

Overall the scheme was felt to be helpful in terms of identifying how compassion is viewed, enacted and appreciated in the participating organisations. Nominations continue to be made to the scheme, which is also indicative of its acceptance by staff and its success. Its adoption was dependent on the level of awareness generated, which in turn was reliant on how it was perceived in the organisation, how it was publicised, and the extent to which it was consistent with organisation wide approaches to staff recognition. There were some concerns expressed about the lack of awareness among staff and the title of the scheme as the term ‘leadership’ is understood in different ways. However the scheme had been implemented at relatively little cost and those who were recognised felt rewarded and the process raised the profile of compassion as an issue.

Analysing Compassion

Alongside the evaluation of the Leading with Compassion Recognition scheme, an analysis of the nominations was undertaken. The 1500 nominations made as part of the scheme at the time of the evaluation, were subject to content analysis (Bengtsson, 2016; Cho and Lee, 2014; Hsieh and Shannon, 2005) and a number of themes developed to reflect how compassion was characterised across the twelve organisations. The analytical approach had inductive and deductive elements to identify the latent content and meaning, and involved the team members reading, and re-reading the nominations; grouping them by type and frequency; referring to existing definitions; and comparing interpretations of the nominations. The aim was to identify how did the nominated person lead with compassion? And - What was the impact on the person making the nomination and/or others? This resulted in a framework of compassion which was developed through nine iterations and is comprised of seven ‘action themes’ and ‘impact themes’. These are set out below:

Action themes

1. Supporting through distress
2. Role Modelling
3. Recognition of staff
4. Kindness
5. Listening and Assurance
6. Discretionary Effort
7. Maintaining morale through change

Impact themes

1. Feeling Secure
2. Feeling Valued
3. Feeling proud
4. Feeling empowered
5. Direct Improvement in Patient Care
6. Creating or maintaining a positive culture
7. Improved emotional resilience

This framework is novel in that it was developed inductively from the details of the nominations compiled on the central database. It is the first typology of compassion we are aware of that has been developed in this way. There are a number of models and frameworks of compassion which exist and these are explored here to locate the compassion framework in a wider theoretical and empirical context and also to identify how this pioneering approach can be further developed.

Many of the nominations depict behaviour which could be described as caring. In work to develop a means of measuring compassion, caring was cited as the enactment of compassion and it was found that patients identified compassion as their greatest need (Burnell *et al.*, 2013). Therefore recognising caring behaviours, as was evident in the analysis of the *Leading with Compassion* recognition scheme nominations, is a route to defining and observing compassion. Whilst Burnell *et al.*'s work approached the concept of compassion from the patients' perspective, and focused on nursing care rather than the recognition of compassion as enacted for all staff and patients, there are similarities between the frameworks (see below). Burnell *et al.*, (2013) also report that the ability to exhibit caring behaviours to patients has benefits for staff in terms of job satisfaction because it is the work they wish to do and so is self-fulfilling. Whilst their survey only focused on patients in hospital, and the compassion recognition scheme encompassed a wider range of services (community; commissioning; mental health services), the framework shares some common ground with the analysis of the recognition scheme nominations. The four elements of compassion identified are:

- 1 **1. Meaningful connection** – establishing personal connections; focusing on the most relevant
- 2 needs for the patient and acting accordingly.
- 3 **2. Patient expectations** – pain control; careful listening; being respectful; offering clear
- 4 explanations and giving timely assistance.
- 5 **3. Caring attributes** – provide hope, kindness and understanding; being empathetic;
- 6 appreciating family /carers needs.
- 7 **4. Capable practitioner** – competence, confidence and requisite knowledge and skill set for
- 8 role.

(Burnell *et al.*, 2013)

It can be seen that the action themes 1 and 5 derived from the analysis of the nominations made as part of the recognition scheme are consistent with the Meaningful connection element of Burrell *et al's* framework. Similarly 4 'maps' across to Caring attributes, and 6- discretionary effort- as identified in the analysis of nominations relates to the patient expectations and being a capable practitioner elements found by Burrell *et al.* (2013). There is further confirmation of the credibility of the framework in other work. For example in an integrative review of six papers which examined studies of how compassion is measured in nurses and other healthcare professionals, Papadopolous and Ali (2015) identified eight themes which emerged from the appraisal of the papers. These were:

- 1. Being empathetic,
- 2. Recognising and ending suffering,
- 3. Being caring,
- 4. Communicating with patients,
- 5. Connecting to and relating with patients,
- 6. Being competent,
- 7. Attending to patients' needs/going the extra mile,
- 8. Involving the patient.

Again there are commonalities here in that 'Being empathetic' (Papadopolous and Ali, 2015) and 'Supporting through distress' (Action Theme) are almost the same. Similarly 'Recognising and ending suffering' (Papadopolous and Ali, 2015) and 'Listening and Assurance' (Action Theme) seem to be matched, and indeed are common with Burnell *et al's* (2013) 'caring attributes'. This indicates a broadly shared understanding of the nature of compassion. However this does not necessarily lend itself to accurate measurement.

The challenges this presents are further demonstrated in two other projects which examined compassion. In a focus group study, forty five academic staff, health care students, clinicians

and service users in nine groups were asked to define compassion in the context of health care (Kneafsey *et al.*, 2015). One theme developed from the participants' responses was 'Compassion: 'A big word that you can't summarise in one', which although may be accurate, highlights the difficulties when seeking to study and/or recognise acts of compassion. The other themes were positive communication and consistency, losing compassion: when the system takes over, and supporting compassionate practice (Kneafsey *et al.*, 2015). The latter two themes indicate the importance of the organisational context with regard to compassion, which was also a focus in the Cultivating Compassion Project (2015) discussed earlier. In the course of this work a 'menu' of indicators for the multiple and diverse ways in which compassion has been expressed by health service staff in practice was produced. The items were presented as intentionally aspirational in order to generate discussion and simulate thought about what could be done differently (Cultivating Compassion 2015).

There were sixty five items identified, organised into themes which are:

1. Towards ourselves;
2. Self -compassion;
3. Supporting each other;
4. Leadership;
5. Organisational culture;
6. Balancing competing demands;
7. Person centred care;
8. Being non-judgemental;
9. Holistic approach to our work;
10. Relating to people.

This framework, whilst including the 'common' elements of support and relating to others, has a much more distinct organisational component-particularly the identification of leadership which resonates with some of the themes arising from the recognition scheme nominations. However this adds further to the emerging picture conveying the complexity of compassion and the difficulties of measuring it.

Based on the premise that without an agreed definition and adequate measures, it is not possible to study compassion, measure compassion or evaluate whether interventions designed to enhance it are effective Strauss *et al.* (2016) conducted a review of nine psychometric compassion measurement scales. In this detailed and comprehensive review they found there was poor internal consistency for the subscales of the measures they

reviewed, insufficient evidence for factor structure and/or failure to examine floor/ceiling effects, test–retest reliability, and discriminant validity, and concluded a suitable robust scale for the measurement of compassion has not yet been developed (Strauss *et al.*, 2016). In response they explored a range of definitions from Buddhist and Western psychological perspectives and identified five components of compassion:

1. Recognition of suffering;
 2. Understanding its universality;
 3. Feeling sympathy, empathy, or concern for those who are suffering (emotional resonance);
 4. Tolerating the distress associated with the witnessing of suffering;
 5. Motivation to act or acting to alleviate the suffering.
- (Strauss *et al.*, 2016)

Again there are parallels here with the Action Themes drawn from the nominations, for example 1 and 1, 1 and 3, and 6 and 4. However as Strauss *et al.* (2016) conclude their review provides a foundation for progressing research into compassion, and more work is needed to investigate the nature of compassion. The distinctive feature of the analysis presented here is the identification of the ‘impact themes’. This provides insight which demonstrates the positive impact of acting compassionately on staff. Further analysis of compassion, as identified through the operation of the recognition scheme, could provide a rich source of data to contribute to the development of knowledge and practice in this area.

Discussion

It is clear that defining and measuring compassion is a complex task, which has been the subject of considerable academic endeavour. This in turn makes it difficult to evaluate the impact of such a scheme on the culture of organisations and to identify precisely where it fits with regard to creating compassionate leadership. However the *Leading with Compassion* scheme appears to have intrinsic value in terms of providing data which can be used to stimulate strategic discussions about how compassion is enacted, its effect on staff, and in that it can also be used to help raise the profile and enactment of compassion in organisations. This can involve:

- Providing information at induction and training sessions about what is expected with regard to compassion and how it is recognised in the organisation(s) involved in the scheme- ‘the way we do things around here’.

- Generating a sense of well-being in both those nominating and nominated. Patients and service users also valued this process.
- Starting the conversation about how organisations can enable or hinder this culture.

However a formal recognition scheme will only be effective if it is part of an overall approach to people management and staff engagement (NHS Employers, 2015). The way this aspect of the introduction and operation of the scheme was managed varied between organisations and was dependent on context. For example in some it was closely aligned with the leadership development programme in the organisation, for others it was more explicitly linked to broader organisational values. There is also a balance to be struck in terms of recognising compassion yet not characterising it as something ‘over and above’ what would be expected of staff. Whilst some concerns were expressed about rewarding behaviour that could and should be reasonably expected by NHS staff, it was generally acknowledged that the scheme was necessary in the current environment of the NHS as the lack of compassion for colleagues in particular, was of concern, and so any organisational effort to address it was welcome. This is particularly important when it is considered that 25% of all NHS staff report they have been bullied in some way (NHS England, 2016). Indeed, the opportunity to recognise staff for being compassionate to colleagues does seem to distinguish this award from other initiatives, which tend to focus on compassion for patients, as does its identification of the impact of compassion on staff. Given the links between staff well-being and compassionate care (Beardsmore and McSherry, 2017; West *et al.*, 2017), this would seem an important component which is often overlooked. The issue of whether anonymity on the part of the person nominating the individual for recognition would increase the number of nominations was raised in the interviews. This is an issue the project team would need to monitor as the scheme developed.

There several limitations of this work that need to be acknowledged. These include the fact that the number of participants contributing to the evaluation was low, given the number of organisations involved. Also the views and experiences of those who have not used the scheme were not accessed, and this may have revealed issues relating to the scheme that were not identified by the participants. However a number of useful insights on the conduct of the scheme were generated.

With regard to the analysis of the content of the nominations, the compassion framework moves beyond broad characterisations of compassion arising as it does from the identification of the specific compassionate acts of staff in their interactions with each other and patients/service users. Several of the themes emerging from this can also be identified in other related work, however what is perhaps distinctive about the approach taken in the recognition scheme is that it captures the impact on staff of being compassionate. This gives the scheme a clear identity and provides an opportunity to give due emphasis to compassion so that it is seen as central to all activity for both patients and staff. This can contribute to the creation of a culture in which compassionate leadership can flourish. Johnson (1992) suggests that the symbols and stories created in organisations contribute to the changes in the other elements of the organisation. Sharing the compassion framework developed in the course of this work more widely could help foster a culture focussed on compassion.

It was noted in the interviews and the focus group that there is a plethora of award schemes and initiatives in health care organisations, and so emphasising that leadership and compassion are synonymous at all levels would be a way of capitalising on this distinctiveness. Schemes which are linked to locally developed values and overall patient care appear to have most support among staff and have the most impact (NHS Employers, 2015). In addition, the detail concerning the nominations made as part of the scheme provide a rich source of data for continuing analysis to further and deepen understanding of the nature of compassion. As Blomberg *et al.* (2016) found, although many interventions to improve compassionate care have been investigated (25 in their review) none of the studies they examined presented sufficiently strong evidence of effectiveness to merit routine implementation of any of the interventions into practice (Blomberg *et al.*, 2016), however they did conclude that some positive outcomes suggest that further investigation of some interventions may be merited.

Conclusion

The Leading with Compassion Recognition scheme is part of a wider trend in UK health care focussed on finding organisational approaches to the provision of compassionate care for patients, and the creation of compassionate organisations which support staff. Whilst it shares some common ground with the programmes reviewed earlier, it is distinctive in the sense that it is designed to highlight and reward compassionate acts by all staff. It has been

welcomed by the staff who have used it, and the analysis of the nominations has generated a novel way of characterising compassion which makes a useful contribution to this developing area of knowledge. A guide has been developed by the project team which is available to organisations that may wish to introduce the scheme as part of their staff well-being and/or compassionate care strategies. It sets out the evidence base and provides a 'step-by-step' framework for introduction of the scheme incorporating case studies and reflections on the original project (Rogers *et al.*, 2017). The intention is that it will enable more organisations to introduce and develop the scheme further. There is an emerging view that compassion is under threat in the high volume, high risk world of modern healthcare. Yet compassion is a varied and complex phenomenon and what it means to be compassionate can be defined and interpreted in many different ways (Mannion, 2014, p. 117). The model of compassion reported here can provide a foundation for continuing work in building understanding of the nature of compassion. In the longer term it represents a useful approach that can help contribute to the development of more compassionate health care organisations which will benefit patients and staff.

1. Actual cost £1.48

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Response to Reviewer's comments

Reviewer Comment	Response
1.The manuscript is interesting and well written, and it is good to see that compassion across the workforce was considered.	Thank you for this supportive comment, much appreciated.
2.On Page 1, NHS should be written in full in the first instance.	This has been done.
3. On Page 2, it would be useful to explain the 6Cs for the benefit of readers who may not be familiar with this concept.	Thank you for pointing this out. Further contextual information has been added on page 2: They are care, compassion, competence, communication, courage and commitment and their purpose is to define a vision to reinforce the values and beliefs that underpin care in an easily understood and consistent way to explain the values of care (Compassion in Practice NHS England, 2012).
4. - I found the use of the words 'leading'/'leadership' somewhat confusing/misleading. How is leadership defined within the context of this study? How do the authors ascertain what good 'leadership' looks like? I was unsure of the extent to which the scheme is associated with leaders as such, or how this scheme might encourage leadership skills in compassionate care. Perhaps these points could be further clarified.	The scheme was based on the belief that there is the potential for all staff to demonstrate leadership. In this context demonstrating and recognising compassion were deemed to be facets of leadership. Additional content and reference material relating this to 'Distributed Leadership has been included on pages 4-5.

5. - I was unsure how the scheme might demonstrate compassion for colleagues, other than the fact that one colleague might nominate another on the basis of a compassionate act.	The nominations made as part of the scheme can identify acts of compassion on the part of staff for colleagues. In most such schemes it is generally only acts of compassion focussed on patients that are recognised. There is no claim made in the paper that the scheme demonstrates or increases levels of compassion between colleagues, rather the conclusion is that recognising such acts is important. Particularly with regard to staff well-being. This is stated on p18: Indeed, the opportunity to recognise staff for being compassionate to colleagues does seem to distinguish this award from other initiatives, which tend to focus on compassion for patients, as does its identification of the impact of compassion on staff.
6. - It would be interesting to see a breakdown of the nominations e.g. who provided the most nominations – patients or staff?	This information has been included on p5. To date 3651 nominations have been made with 59% of the total made by staff and 49% by service users.
7. It appears that the nominations were not anonymous, and perhaps the names of the people making the nominations should not have been disclosed	Anonymity was not part of the scheme, although some of the interviewees raised this as an issue (p10, 11). A further comment has been added on p18 stating: The issue of whether anonymity on the part of the person nominating the individual for recognition would increase the number of nominations was raised in the interviews. This is an issue the project team would need to monitor as the scheme developed.
8. It was interesting to read the comments made during the interviews and focus groups. It would be useful to know if any patients were included in the interviews and focus groups.	Thank you for this supportive comment. The interviews and focus groups yielded some fascinating insights. The nature of the project meant that it did not involve patients. This is an important area to examine in future work. Changes have been made on p5 & 6 to clarify that only staff were involved in the interviews.
9. It is a pity that there seems to have been some problems regarding the levels of awareness of the existence of the scheme. Perhaps the authors could suggest ways in which the scheme might be more effectively rolled out in the future.	This was variable depending on the approach taken in each organisation. Recommendations concerning how best to approach this are included in the 'how to' guide (see response to comment 12)

10. It is interesting that analysis of the nominations generated a framework of compassion which could have wider applications (although this framework has similarities with other frameworks, as the authors have pointed out).	Thank you for this comment. We hope the framework will inform the work of colleagues working in this area.
11. Overall, it appears that the scheme represents a novel approach, which is distinctive in rewarding compassion. However, although the scheme raises the profile of compassion, it implies that it is not always in place. As such, the scheme might be discouraging for some, and could lead to low morale, and additional pressure. It would be interesting if the authors could provide further clarification as to how such issues might be addressed	Thank you for this comment. The introduction of the scheme does not imply it is not in place-rather it is a means of making the excellent compassionate practice that goes in every day more visible. The scheme is something that organisations can use to recognise compassion and increase morale by valuing staff.
12. It would be useful if some further information could be included in the discussion/conclusion sections with regard to the longer term plans for the scheme, how it could be further developed, what can be learned from it, and how it might be incorporated into training	Its potential for incorporation in Induction and training activities is noted on p 17. Information concerning the development of the scheme has been added to the conclusion and is reproduced below. A guide has been developed by the project team which is available to organisations that may wish to introduce the scheme as part of their staff well-being and/or compassionate care strategies. It sets out the evidence base and provides a 'step-by-step' framework for introduction of the scheme incorporating case studies and reflections on the original project (Rogers et al 2017). The intention is that it will enable more organisations to introduce and develop the scheme further